FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039115

Facility Name: WHEATON CARE CENTER

Address: 1325 MANCHESTER ROAD (Number) WHEATON (City) 60187 (Zip Code)

County: DUPAGE

Telephone Number: (630) 668-2500 **Fax #** (630) 668-0232

IDPA ID Number: 363905787001

Date of Initial License for Current Owners: 09/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,056	150	566	4,772	8
9	SNF/PED					9
10	ICF	36,500	1,348		37,848	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,556	1,498	566	42,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.93%

D. How many bed-hold days during this year were paid by Public Aid?
1,010 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 566

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	211,509	18,780	11,015	241,304		241,304	(10,360)	230,945			1
2	Food Purchase		150,298		150,298	(15,330)	134,968	3,294	138,262			2
3	Housekeeping	131,564	20,054		151,618		151,618	(640)	150,978			3
4	Laundry	73,296	16,420		89,716		89,716		89,716			4
5	Heat and Other Utilities			119,053	119,053		119,053	1,103	120,156			5
6	Maintenance	55,000		69,282	124,282		124,282	3,441	127,723			6
7	Other (specify):*							2,858	2,858			7
8	**TOTAL General Services**	471,369	205,552	199,350	876,271	(15,330)	860,941	(303)	860,638			8
	B. Health Care and Programs											
9	Medical Director			610	610		610		610			9
10	Nursing and Medical Records	1,299,383	29,119	86,303	1,414,805		1,414,805	5,254	1,420,059			10
10a	Therapy	43,837	804	3,947	48,588		48,588		48,588			10a
11	Activities	82,407	9,836	2,304	94,547		94,547	(2)	94,545			11
12	Social Services	149,316		13,203	162,519		162,519	9	162,528			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							12,436	12,436			15
16	**TOTAL Health Care and Programs**	1,574,943	39,759	106,367	1,721,069		1,721,069	17,697	1,738,766			16
	C. General Administration											
17	Administrative			126,174	126,174		126,174	22,469	148,643			17
18	Directors Fees											18
19	Professional Services			205,730	205,730		205,730	(167,076)	38,654			19
20	Dues, Fees, Subscriptions & Promotions			47,567	47,567		47,567	(17,452)	30,115			20
21	Clerical & General Office Expenses	103,101	13,515	82,455	199,071		199,071	28,916	227,987			21
22	Employee Benefits & Payroll Taxes			322,020	322,020	15,330	337,350	(27,499)	309,851			22
23	Inservice Training & Education			995	995		995		995			23
24	Travel and Seminar			1,064	1,064		1,064	860	1,924			24
25	Other Admin. Staff Transportation			6,972	6,972		6,972		6,972			25
26	Insurance-Prop.Liab.Malpractice			97,440	97,440		97,440	776	98,216			26
27	Other (specify):*							24,118	24,118			27
28	**TOTAL General Administration**	103,101	13,515	890,417	1,007,033	15,330	1,022,363	(134,888)	887,475			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,149,413	258,826	1,196,134	3,604,373		3,604,373	(117,495)	3,486,878			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WHEATON CARE CENTER #0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,037	56,037		56,037	11,331	67,368			30
31	Amortization of Pre-Op. & Org.			2,059	2,059		2,059		2,059			31
32	Interest			17,348	17,348		17,348	(17,348)				32
33	Real Estate Taxes			48,020	48,020		48,020	1,914	49,934			33
34	Rent-Facility & Grounds			654,680	654,680		654,680	2,964	657,644			34
35	Rent-Equipment & Vehicles			3,730	3,730		3,730	2,156	5,886			35
36	Other (specify):*											36
37	TOTAL Ownership			781,874	781,874		781,874	1,017	782,891			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,767	23,267	63,034		63,034	(1,029)	62,005			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		39,767	90,610	130,377		130,377	(1,029)	129,348			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,149,413	298,593	2,068,618	4,516,624		4,516,624	(117,507)	4,399,117			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,726	30		9
10	Interest and Other Investment Income	(25,459)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,059)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,790)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,635)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(40,872)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,872)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,507)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

WHEATON CARE CENTER

ID# 0039115

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL ON LTC-COPE	$ (1,734)	20	1
2	BANK CHARGES	(1,564)	21	2
3	TRUST FEES	(300)	20	3
4	LEGAL FEES	(1,504)	19	4
5	LOTTERY TICKET	(80)	22	5
6	COLLECTION EXPENSE	(47)	21	6
7	THEFT LOSS	(2,036)	21	7
8	STATE REPLACEMENT TAX	(6,525)	21	8
9				9
10				10
11				11
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97				97
98				98
99				99
100				100
101	Total	(13,790)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(1,128)	(5,389)	(3,843)					(10,360)	1
2	Food Purchase	(53)		(95)			3,442						3,294	2
3	Housekeeping							(640)					(640)	3
4	Laundry													4
5	Heat and Other Utilities			1,103									1,103	5
6	Maintenance			2,158		1,277	6						3,441	6
7	Other (specify):*				1,964	627	267						2,858	7
8	**TOTAL General Services**	(53)		3,166	1,964	776	(1,674)	(4,483)					(303)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(27)		7,910	4	(2,633)					5,254	10
10a	Therapy													10a
11	Activities			1	(3)								(2)	11
12	Social Services					9							9	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				11,346	1,090							12,436	15
16	**TOTAL Health Care and Programs**			(26)	11,343	9,009	4	(2,633)					17,697	16
	C. General Administration													
17	Administrative			260	6	22,098	105						22,469	17
18	Directors Fees													18
19	Professional Services	(1,504)		(165,782)			210						(167,076)	19
20	Fees, Subscriptions & Promotions	(7,093)		(10,370)			11						(17,452)	20
21	Clerical & General Office Expenses	(46,172)		10,642	1,198	63,097	151						28,916	21
22	Employee Benefits & Payroll Taxes	(80)			(27,419)								(27,499)	22
23	Inservice Training & Education													23
24	Travel and Seminar			635			225						860	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			776									776	26
27	Other (specify):*				12,115	12,003							24,118	27
28	**TOTAL General Administration**	(54,849)		(163,839)	(14,100)	97,198	702						(134,888)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,902)		(160,699)	(793)	106,983	(968)	(7,116)					(117,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,726		7,605									11,331	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,459)		8,111									(17,348)	32
33	Real Estate Taxes			1,914									1,914	33
34	Rent-Facility & Grounds			2,958			6						2,964	34
35	Rent-Equipment & Vehicles			2,148			8						2,156	35
36	Other (specify):*													36
37	TOTAL Ownership	(21,733)		22,736			14						1,017	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,029)						(1,029)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(1,029)						(1,029)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(76,635)		(137,963)	(793)	106,983	(1,983)	(7,116)					(117,507)	45

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED	SEE ATTACHED			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 1,103	$ 1,103	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	2,158	2,158	16
17	V	10	Nursing	32	Care Centers, Inc.	100.00%	5	(27)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	1	1	18
19	V	19	Professional Fees	172,209	Care Centers, Inc.	100.00%	6,427	(165,782)	19
20	V	20	Dues and Subscriptions	11,224	Care Centers, Inc.	100.00%	854	(10,370)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	10,642	10,642	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	635	635	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	776	776	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	7,605	7,605	24
25	V	32	Interest		Care Centers, Inc.	100.00%	8,111	8,111	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,914	1,914	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,958	2,958	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	2,148	2,148	28
29	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			29
30	V	02	Food	95	Care Centers, Inc.	100.00%		(95)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	260	260	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 183,560			$ 45,597	$ * (137,963)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	14,644	Care Centers, Inc.	100.00%	14,644		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,964	1,964	17
18	V	10	Nursing Salary	65,765	Care Centers, Inc.	100.00%	65,765		18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary	2,304	Care Centers, Inc.	100.00%	2,301	(3)	20
21	V	12	Social Service Salary	13,203	Care Centers, Inc.	100.00%	13,203		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	11,346	11,346	22
23	V	17	Administration Salary	66,175	Care Centers, Inc.	100.00%	66,181	6	23
24	V	21	Office Salary	19,521	Care Centers, Inc.	100.00%	20,719	1,198	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	12,115	12,115	25
26	V	22	Employee Benefits	27,419	Care Centers, Inc.	100.00%		(27,419)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 209,031			$ 208,238	$ * (793)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 4,490	Care Centers, Inc.	100.00%	$ 3,362	$ (1,128)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	1,277	1,277	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	627	627	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	7,910	7,910	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	9	9	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,090	1,090	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	22,098	22,098	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	63,097	63,097	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	12,003	12,003	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,490			$ 111,473	$ * 106,983	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 8,210	Care Centers, Inc. - Health Systems Division	100.00%	$ 831	$ (7,379)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	3,442	3,442	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	6	6	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	4	4	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	105	105	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	210	210	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	11	11	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	151	151	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	225	225	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	6	6	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	8	8	25
26	V	39	Ancillary Enteral Supplies	1,771	Care Centers, Inc. - Health Systems Division	100.00%	742	(1,029)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,990	1,990	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	267	267	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,981			$ 7,998	$ * (1,983)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 28,364	XCEL Medical Supply, LLC	100.00%	$ 24,521	$ (3,843)	15
16	V	03	Housekeeping	4,727	XCEL Medical Supply, LLC	100.00%	4,087	(640)	16
17	V	10	Nursing	19,434	XCEL Medical Supply, LLC	100.00%	16,801	(2,633)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,525			$ 45,409	$ * (7,116)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 58,911	$ 58,911	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	58,911				(58,911)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 58,911			$ 58,911	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	21.07%	See Attached	1.27	1.76%	Mgt. Fees	$ 60,000	17-3	1
2	Nathan Langsner	Relative	Administrative	0%	See Attached	1.04	2.60%	Alloc Salary	3,523	17-3	2
3	Nathan Langsner	Relative	Administrative	0%	See Attached			Alloc Salary	247	17-7	3
4	Melissa Rothner	Owner	Clerical	4.07%	See Attached		0.00	Alloc Salary	26	21-7	4
5	Mark Steinberg	Relative	Administrative	0	See Attached	1.3	2.60%	Alloc Salary	1,176	17-7	5
6	Norman Goldberg	Owner	Administrative	4.07%	See Attached	1.3	2.60%	Alloc Salary	2,708	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,680		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	42,620	$ 1,103	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		42,620	2,158	2
3	10	Nursing	Patient Days	1,640,756	39	205		42,620	5	3
4	11	Activities	Patient Days	1,640,756	39	51		42,620	1	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		42,620	6,427	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		42,620	854	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		42,620	10,642	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		42,620	635	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		42,620	776	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		42,620	7,605	10
11	32	Interest	Patient Days	1,640,756	39	312,254		42,620	8,111	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		42,620	1,914	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		42,620	2,958	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		42,620	2,148	14
15	17	Administration	Patient Days	1,640,756	39	10,000		42,620	260	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 45,597	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		14,644	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			1,964	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		65,765	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201		2,301	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		13,203	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			11,346	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		66,181	9
10	21	Office Salary	Direct Cost			584,278	584,278		20,719	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			12,115	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 208,238	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	42,620	3,362	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	42,620	1,277	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		42,620	627	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	42,620	7,910	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	42,620	9	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		42,620	1,090	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	42,620	22,098	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	42,620	63,097	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		42,620	12,003	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 111,473	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		9,981	831	1
2	02	Food	Billable Income	2,191,458		834,365		9,981	3,442	2
3	06	Maintenance	Billable Income	2,191,458		1,400		9,981	6	3
4	10	Nursing	Billable Income	2,191,458		850		9,981	4	4
5	17	Administration	Billable Income	2,191,458		23,000		9,981	105	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		9,981	210	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		9,981	11	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		9,981	151	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		9,981	225	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		9,981	6	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		9,981	8	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		9,981	742	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	9,981	1,990	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		9,981	267	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 7,998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 328-7600
Fax Number: (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 24,521	1
2	03	Housekeeping	Direct Allocation						4,087	2
3	10	Nursing	Direct Allocation						16,801	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 45,409	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 58,911	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 58,911	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB BANK		X	LINE OF CREDIT				174,149			17,348	6
7												7
8												8
9	TOTAL Facility Related						$	$ 174,149			$ 17,348	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(17,348)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17,348)	14
15	TOTALS (line 9+line14)						$	$ 174,149			$ (0)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (25,459)	1
2	CARE CENTERS, INC.	X		ALLOCATION							8,111	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (17,348)	21

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	53,238	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,307	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,931)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,864	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	49,933	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	49,846	8
1998	50,100	9
1999	49,738	10
2000	50,704	11
2001	49,393	12

2001 RE TAX BILL = 49,393*1.05=51,864 ACCRUAL
ALLOCATION FROM CARE CENTERS-$1,914

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WHEATON CARE CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847)236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-17-114-010	Long Term Care Property	$ 49,393.36	$ 49,393.36
2.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 1,825.11	$ 1,825.11
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,218.47	$ 51,218.47

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WHEATON CARE CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,963
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 2,059
4. Dates Incurred: _____

Nature of Costs: Organization Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	CCI ALLOCATION			$ 10,926	1
2					2
3	TOTALS			$ 10,926	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20	2,067	2,067	19,329	9
10	Various			1994	104,965		20	5,250	5,250	45,551	10
11	Various			1995	16,968		20	849	849	6,592	11
12	Various			1996	158,287		20	7,915	7,915	51,612	12
13	Various			1997	103,690		20	5,187	5,187	28,973	13
14	Various			1998	56,873		20	2,846	2,846	12,443	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		28,996	1,210		1,241	31	5,214	68
69	Financial Statement Depreciation			56,038			(56,038)		69
70	TOTAL (lines 4 thru 69)		$ 511,110	$ 57,248		$ 25,355	$ (31,893)	$ 169,714	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 511,110	$ 57,248		$ 25,355	$ (31,893)	$ 169,714	1
2	PLUMBING RENOV	1999	716		20	36	36	144	2
3	WINDOW GLASS	1999	735		20	37	37	148	3
4	ELECTRIC RENOV	1999	1,245		20	62	62	248	4
5	ELECTRIC RENOV	1999	610		20	31	31	124	5
6	SPRINKLER SYS	1999	3,250		20	163	163	638	6
7	PLUMBING RENOV	1999	950		20	48	48	176	7
8	PLUMBING RENOV	1999	750		20	38	38	133	8
9	PAINTING	1999	999		20	50	50	175	9
10	WALLPAPER	1999	2,700		20	135	135	461	10
11	PLUMBING RENOV	1999	1,588		20	79	79	263	11
12	DECORATING	1999	2,569		20	128	128	427	12
13	SEWER RENOV	1999	710		20	36	36	120	13
14	PLUMBING	1999	1,807		20	90	90	293	14
15	FALL CLEANUP	1999	1,492		20	75	75	238	15
16	PAINTING	1999	1,165		20	58	58	179	16
17	CARPETING	2000	7,597		20	380	380	1,140	17
18	REMOVE WATER SOFTNER	2000	1,500		20	75	75	219	18
19	A/C RENOV/PLUMBING	2000	599		20	30	30	80	19
20	TREE REMOVAL	2000	4,850		20	243	243	628	20
21	A/C RENOV	2000	1,286		20	64	64	165	21
22	A/C RENOV	2000	1,877		20	94	94	235	22
23	HOT WATER PUMP	2000	862		20	43	43	104	23
24	HOT WATER PUMP	2000	1,032		20	52	52	126	24
25	HVAC	2000	637		20	32	32	77	25
26	DRAPES	2000	1,838		20	92	92	215	26
27	CARPETING	2000	4,682		20	234	234	546	27
28	PIPING RENOV	2000	2,945		20	147	147	343	28
29	A/C RENOV	2000	998		20	50	50	117	29
30	WATER RENOV	2000	1,248		20	62	62	145	30
31	MOTOR RENOV	2000	672		20	34	34	79	31
32	A/C RENOV/PLUMBING	2000	2,025		20	101	101	227	32
33	A/C RENOV/PLUMBING	2000	777		20	39	39	88	33
34	TOTAL (lines 1 thru 33)		$ 567,821	$ 57,248		$ 28,193	$ (29,055)	$ 178,015	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 567,821	$ 57,248		$ 28,193	$ (29,055)	$ 178,015	1
2	A/C RENOV/PLUMBING	2000	3,346		20	167	167	376	2
3	SHINGLES	2000	2,200		20	110	110	238	3
4	A/C RENOV/PLUMBING	2000	756		20	38	38	82	4
5	DOORS	2000	544		20	14	14	39	5
6	WATER HEATER RENOV	2000	5,985		20	153	153	390	6
7	WATER HEATER RENOV	2000	665		20	17	17	42	7
8	FAUCETS	2000	818		20	21	21	45	8
9	NURSE CALL SYSTEM	2000	6,800		20	1,189	1,189	3,826	9
10	PHONE SYS VOICE MAIL	2001	4,582		20	229	229	458	10
11	FAUCET AND SINK	2001	780		20	39	39	78	11
12	WALL MOUNT OVERLAP C	2001	3,798		20	190	190	380	12
13	EXHAUST DUCT WORK	2001	832		20	42	42	84	13
14	NURSE CALL SYSTEM	2001	1,800		20	90	90	180	14
15	POWER ROD MAINE LINE	2001	813		20	41	41	82	15
16	FAN, MOTOR, ZOOM SPT	2001	529		20	26	26	52	16
17	HOT WATER SUPPLY REP	2001	1,434		20	72	72	138	17
18	VOICE MAIL SUPPLY RE	2001	2,488		20	124	124	238	18
19	PHONE SYSTEM	2001	4,234		20	212	212	406	19
20	DRAPES	2001	10,722		20	536	536	1,027	20
21	FIRE/ALARM EQUIP-WIN	2001	3,013		20	151	151	277	21
22	INSTALL NEW DRAPES &	2001	1,920		20	96	96	176	22
23	SPRINKLER SYSTEM REP	2001	1,250		20	63	63	116	23
24	SEWER LINE	2001	2,165		20	108	108	189	24
25		2001	599		20	30	30	53	25
26	BOILER ROOM FLOW VAL	2001	825		20	41	41	72	26
27	GROUNDS CLEANUP	2001	1,200		20	60	60	105	27
28	ELECTRICAL RENOVATIO	2001	943		20	47	47	78	28
29	DOOR CLOSERS	2001	569		20	28	28	47	29
30	WASCOMAT COMPUER REP	2001	545		20	27	27	45	30
31	ELECTRICAL RENOVATIO	2001	550		20	28	28	47	31
32	REPR/DAMG/MISING SHG	2001	500		20	25	25	42	32
33	INSTALL KEY CYLINDER	2001	1,041		20	52	52	87	33
34	TOTAL (lines 1 thru 33)		$ 636,067	$ 57,248		$ 32,259	$ (24,989)	$ 187,510	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 636,067	$ 57,248		$ 32,259	$ (24,989)	$ 187,510	1
2	HVAC	2001	981		20	49	49	82	2
3	PLUMBING	2001	1,563		20	78	78	124	3
4	PAINTING	2001	719		20	36	36	57	4
5	WINING	2001	575		20	29	29	44	5
6	PLUMBING	2001	691		20	35	35	53	6
7	P/A SYSTEM	2001	1,199		20	60	60	90	7
8	A/C REPAIR	2001	669		20	67	67	95	8
9	MASONRY	2001	1,600		20	80	80	100	9
10	HVAC	2001	691		20	35	35	44	10
11	PLUMBING	2001	1,240		20	62	62	78	11
12	HVAC	2001	641		20	32	32	40	12
13	GUTTERS	2001	575		20	58	58	67	13
14	PA SYSTEM	2001	1,096		20	110	110	174	14
15	PLUMBING	2002	3,707		20	340	340	371	15
16	DOOR SYSTEMS	2002	2,810		20	258	258	281	16
17	PLUMBING	2002	921		20	84	84	84	17
18	PAINT	2002	628		20	58	58	58	18
19	CABINETS	2002	2,976		20	165	165	165	19
20	BOILER	2002	1,716		20	129	129	129	20
21	HVAC	2002	759		20	32	32	32	21
22	CARPETING	2002	1,526		20	73	73	73	22
23	BOILER	2002	700		20	15	15	15	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 664,050	$ 57,248		$ 34,144	$ (23,104)	$ 189,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI Alloc		1996		$	$ 692	35	$ 771	$ 79	$ 5,114	4
5	CCI Alloc		2002		15,056	28	35	42	14	42	5
6											6
7											7
8											8
	Improvement Type**										
9	Care Center, Inc. Allocation			2002		257	20	17	(240)		9
10	Care Center, Inc. Allocation			2001		1	20	4	3		10
11	Care Center, Inc. Allocation			2000		1	20	2	1		11
12	Care Center, Inc. Allocation			1999		12	20	24	(12)		12
13	Care Center, Inc. Allocation			1998		5	20	10	5		13
14	Care Center, Inc. Allocation			1997		49	20	100	51		14
15	Care Center, Inc. Allocation			1996		129	20	197	68		15
16	Care Center, Inc. Allocation-Indiana			1997		1	20	16	15		16
17	Care Center, Inc. Allocation			1994		6	20		(6)		17
18	Care Center, Inc. Allocation			1993		3	20		(3)		18
19											19
20	Care Center, Inc. Allocation			2002	13,940	26	20	58	32	58	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,996	$ 1,210		$ 1,241	$ 7	$ 5,214	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 306,812	$ 2,610	$ 29,369	$ 26,759	10	$ 157,205	71
72	Current Year Purchases	17,298	842	1,307	465	10	1,323	72
73	Fully Depreciated Assets	7,875				10	7,875	73
74								74
75	TOTALS	$ 331,985	$ 3,452	$ 30,676	$ 27,224		$ 166,403	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CCI ALLOCATION		$ 17,499	$ 2,944	$ 2,550	$ (394)	5	$ 9,569	76
77										77
78										78
79										79
80	TOTALS			$ 17,499	$ 2,944	$ 2,550	$ (394)		$ 9,569	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,024,460	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,644	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,370	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,726	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 365,738	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NWOS GENERAL PARTNERSHIP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		123		$ 654,680			3
4	Additions							4
5								5
6	Allocation from Care Centers				2,964			6
7	TOTAL		123		$ 657,644 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 09/01/93
Ending 08/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 5,886 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 4,613	$		$ 4,613	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,183			2,183	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			16,471			16,471	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				11,552		11,552	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						28,215		28,215	13
14	TOTAL			$		$ 23,267	$ 39,767		$ 63,034	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,333	$	1
2	Cash-Patient Deposits	33,108		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	990,620		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,218		6
7	Other Prepaid Expenses	3,077		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	480,624		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,732,980	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	588,568		15
16	Equipment, at Historical Cost	344,385		16
17	Accumulated Depreciation (book methods)	(375,602)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	307,860		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 865,211	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,598,191	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 194,715	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,601		28
29	Short-Term Notes Payable	174,149		29
30	Accrued Salaries Payable	156,520		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,376		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,864		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,800		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 620,025	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 620,025	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,978,166	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,598,191	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,591,790	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,591,790	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	386,376	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 386,376	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,978,166	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,866,137	1
2	Discounts and Allowances for all Levels	(97,131)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,769,006	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,738	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 85,738	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,647	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,419	19
20	Radiology and X-Ray	600	20
21	Other Medical Services	3,105	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,771	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,485	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,485	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,903,000	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	876,271	31
32	Health Care	1,721,069	32
33	General Administration	1,007,033	33
	B. Capital Expense		
34	Ownership	781,874	34
	C. Ancillary Expense		
35	Special Cost Centers	63,034	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,516,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	386,376	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 386,376	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,888	2,144	51,692	24.11	2
3	Registered Nurses	11,591	13,518	275,002	20.34	3
4	Licensed Practical Nurses	13,592	14,976	348,577	23.28	4
5	Nurse Aides & Orderlies	45,041	49,540	591,352	11.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,773	2,944	43,837	14.89	8
9	Activity Director	1,920	2,129	31,079	14.60	9
10	Activity Assistants	5,868	6,151	51,328	8.34	10
11	Social Service Workers	10,509	11,504	149,316	12.98	11
12	Dietician	428	530	8,107	15.30	12
13	Food Service Supervisor	1,600	1,795	24,020	13.38	13
14	Head Cook	5,103	5,756	59,200	10.28	14
15	Cook Helpers/Assistants	12,236	13,230	120,182	9.08	15
16	Dishwashers					16
17	Maintenance Workers	3,765	4,102	55,000	13.41	17
18	Housekeepers	14,008	15,377	131,564	8.56	18
19	Laundry	8,265	8,896	73,296	8.24	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,226	9,721	103,101	10.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,780	3,000	32,760	10.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	149,593	165,313	$ 2,149,413 *	$ 13.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 6,525	01-03	35
36	Medical Director	Monthly	610	09-03	36
37	Medical Records Consultant	Monthly	4,816	10-03	37
38	Nurse Consultant	9	450	10-03	38
39	Pharmacist Consultant	Monthly	2,007	10-03	39
40	Physical Therapy Consultant	20	1,089	10a-03	40
41	Occupational Therapy Consultant	53	2,858	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI Salary		85,762	Various	47
48					48
49	TOTAL (lines 35 - 48)	242	$ 104,117		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	152	$ 8,426	10-03	50
51	Licensed Practical Nurses	143	4,839	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	295	$ 13,265		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ADMINISTRATORS SALARY PAID			$
THROUGH CCI			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
ADMINISTRATOR SALARY CCI	$ 63,368
ASSISTANT ADMINISTRATOR CCI	2,806
MANAGEMENT FEES - ERIC ROTHNER	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 126,175
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE	LEGAL	$ 2,979
FR&R	ACCOUNTING	18,932
CROWE CHIZEK	ACCOUNTING	412
TEG SERVICES	OTHER PROFESSIONAL	225
CARE CENTERS	OTHER PROFESSIONAL	2,813
CARE CENTERS	BOOKKEEPING	25,092
CARE CENTERS	HOME OFFICE	103,320
CARE CENTERS	ANCILLARY ADMIN SERVICI	14,760
CARE CENTERS	ACCOUNTING	15,000
CARE CENTERS	LEGAL	11,224
SEE ATTACHED SCHEDULE	DATA PROCESSING	10,283
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	690
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 205,730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,170
Unemployment Compensation Insurance	17,108
FICA Taxes	158,930
Employee Health Insurance	62,213
Employee Meals	15,330
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	7,916
MISC EMPL WELL	2,184
TOTAL (agree to Schedule V, line 22, col.8)	$ 309,851

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,260
Health Care Worker Background Check	
(Indicate # of checks performed 106)	1,138
LICENSES	780
DUES	6,072
PUBLIC RELATIONS	16,283
CARE CENTER ALLOCATION	865
Less: Public Relations Expense	(16,283)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,115

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEMINAR	1,064
CARE CENTER ALLOCATION	860
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,924

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL ON LTC - $5678.92**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,519** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,343**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,330** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **NO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees